

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Please 4 may be renewed by the hospital or attending physician.

MEDICAL CERTIFICATION

1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST HOWARD	MIDDLE C	LAST ALDER	2a. DATE OF DEATH OCTOBER 4, 1986	MONTH DAY YEAR	2b. HOUR 6:45P M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR April 13, 1917	6. AGE (IN YEARS LAST BIRTHDAY) 69		IF UNDER 1 YEAR MONTHS YRS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE COUNTRY Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County MD					
10. CITY OR TOWN OF DEATH PERRY POINT, MD	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA MEDICAL CENTER	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor					12b. KIND OF BUSINESS OR INDUSTRY Insurance	
13a. STATE Maryland	13b. COUNTY ✓	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS, ZIP CODE 4319 Grandview Avenue 21211				
14. FATHER'S NAME FIRST Clarence MIDDLE Arthur LAST Alder			15. MOTHER'S MAIDEN NAME FIRST Fannie MIDDLE Pearl LAST Perego					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES <input checked="" type="checkbox"/> NO OR UNKNOWN <input type="checkbox"/>			16b. SOCIAL SECURITY NO. WW II 166-12-6623	17. INFORMANT Priscilla Alder	ADDRESS 4319 Grandview Ave. 21211			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-PULMONARY ARREST						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____								
DUE TO, OR AS A CONSEQUENCE OF (c) _____								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a								
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN		COUNTY	STATE		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from SEPTEMBER 22, 1986 , to OCTOBER 4, 1986 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on OCTOBER 4, 1986 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (we) not view the body after death.								
22b. SIGNATURE Michael Taylor, M.D.			DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 10/4/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL TAYLOR, M.D.			22e. ADDRESS VA MEDICAL CENTER, PERRY POINT, MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 10/08/86	23c. NAME OF CEMETERY OR CREMATORIAL Arlington National	23d. LOCATION CITY OR TOWN Arlington, Virginia	23e. DATE REC'D. BY REGISTRAR OCT 07 1986		23f. REGISTRAR'S SIGNATURE <i>[Signature]</i>		
24. FUNERAL DIRECTOR NAME BURGEE FUNERAL HOME, BALTIMORE, MD.				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the Hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon copy of page 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked "Yes" (see above), any injury or other traumatic event must be mentioned in Part 1a.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 6 28 904					
1 - FOR STATE REGISTRAR										REG. NO.					
4. DECEASED NAME			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
BARBARA			ANN		BAUGHER	Oct. 22 1986						16:35 M			
1. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			
Female			White			Month Day Year			46			MONTHS DAYS		IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland			U.S.A.			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			CECIL			CECIL			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			MD.			
Elkton			Union Hospital of Cecil County			Sewing			Clothing Mfa.						
13a. STATE			13b. COUNTY			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE						
Maryland			Cecil			Elkton			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			238 E. Main St., 21921			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			17. INFORMANT			ADDRESS			
George			Mary			No			Mary Ruth Ward,			Elkton, Md. 21921			
FIRST			LAST			MIDDLE			LAST			LAST			
16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c)			19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
220 40 1920			Mary Ruth Ward,			PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a)						IMMEDIATE CAUSE (a)			Pulmonary embolism						
DUE TO, OR AS A CONSEQUENCE OF						DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						(b) Pneumonia									
						(c) Cut cell carcinoma of lung with brain metastasis									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a															
20a. DATE OF OPERATION			20b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20c. AUTOPSY?			20d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
			HOUR A.M. MONTH DAY YEAR			P.M. 19									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION			CITY OR TOWN			COUNTY STATE			
						STREET									
22a. I certify that (this hospital) attended the deceased from 5-29-73, 19 to 10-22-86, that (we) lost															
saw the deceased alive on 10-22-86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.															
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED						
Dr. Jui-Chin Hsu, M.D.												10/25/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS												
Dr. Jui-Chin Hsu, M.D.			223 W. Main St. Elkton, Md. 21921												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION						
Burial			10/25/86			Rose Bank Cemetery			CITY OR TOWN						
24. FUNERAL DIRECTOR			NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
Hicks Home for Funerals,			Elkton, Md.						10/25/86						

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked with a (b) 18 shortly after death, the medical examiner should be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8628905	
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
Napoleon Joseph Benoit Jr					10/21/86					2016 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS (LAST BIRTHDAY))		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Auburn, Mass.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED X MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil		MD.			
10. CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. School Teacher		12b. KIND OF BUSINESS OR INDUSTRY		21921			
13a. STATE Md.		13b. COUNTY Cecil	13c. CITY OR TOWN Elkton	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 12 Mary Jane Lane		21921			
14. FATHER'S NAME FIRST Napoleon Joseph Benoit		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST Deloria		MIDDLE	LAST Latour	21921			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 2		17. INFORMANT		ADDRESS		Elkton, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		MYOCARDIAL INFARCTION PART I. ATHEROSCLEROTIC HEART DISEASE SEVERAL YEARS APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 HOURS									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) ATHEROSCLEROTIC HEART DISEASE SEVERAL YEARS DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (b) (1) (this hospital) attended the deceased from 10/21/86 19 to 10/21/86 19, that (b) (2) (we) last saw the deceased alive on 10/21/86 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (b) (3) (we) did not view the body after death.											
22b. SIGNATURE ANANT B. SINGH, MD		22c. DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input checked="" type="checkbox"/>		22d. DATE SIGNED 10/21/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANANT B. SINGH, MD		22e. ADDRESS UNION HOSPITAL ELKTON, MD 21921									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-24-86		23c. NAME OF CEMETERY OR CASKA Immac. Conception		23d. LOCATION CITY OR TOWN Cherry Hill		COUNTY Cecil		STATE Md.	
24. FUNERAL DIRECTOR NAME Dee Gee Funeral Home		ADDRESS EIKTON, MD		25a. DATE REC'D. BY REGISTRAR OCT 27 1986		25b. REGISTRAR'S SIGNATURE Julia S. Wilson, R.R.					

SA 152-00



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please do not be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-trust permit. Then please remove carbon paper and attach to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic condition, attach a medical certificate.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 86 28406	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
BETHANY			J	O	BIERLY	10	31	1986	3:10 P.M.		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH 11 DAY 22 YEAR 1982			6. AGE (IN YEARS LAST BIRTHDAY) 3 1/2 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH CECIL			MD.	
10. CITY OR TOWN OF DEATH PORT DEPOSIT		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 10 TENNIS LANE 21904		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) —			12b. KIND OF BUSINESS OR INDUSTRY —				
13a. STATE MD		13b. COUNTY CECIL		13c. CITY OR TOWN PORT DEPOSIT			13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 10 TENNIS LANE		
14. FATHER'S NAME FIRST CRAIG		MIDDLE R.		15. MOTHER'S MAIDEN NAME LAST BIERLY			16. SOCIAL SECURITY NO. —		17. INFORMANT MOTHER		
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		18b. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 MIN.		18c. IMMEDIATE CAUSE (a) PART I. DEATH WAS CAUSED BY RESPIRATORY ARREST		18d. DUE TO, OR AS A CONSEQUENCE OF (b) EPENDYMOA OF POSTERIOR FOSSA 2 1/2 yrs		18e. DUE TO, OR AS A CONSEQUENCE OF (c)			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION 1984		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CRANIOTOMY FOR EPENDYMOA					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from 11/26/1984 to 10/31/1986, that (I) (we) last saw the deceased alive on 10/27/1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Maria Gumbinas, M.D.		22c. DEGREE		ATTENDING MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 10/31/86					
22e. PHYSICIAN'S NAME (TYPE OR PRINT) MARIA GUMBINAS, M.D.		22f. ADDRESS 22 SO. GREENE ST. BALTIMORE, MD.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 3, 1986		23c. NAME OF CEMETERY OR CEMETORY Hopewell Cemetery		23d. LOCATION CITY OR TOWN Port Deposit		COUNTY Cecil		STATE Md.	
24. FUNERAL DIRECTOR Lee A. Patterson & Son, Perryville, Md.		25a. ADDRESS Lee A. Patterson & Son, Perryville, Md.		25b. DATE REC'D. BY REGISTRAR NOV 6 1986		25c. REGISTRAR'S SIGNATURE					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be detached for use on the burial/transit permit. Then please remove carbon paper. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical certification section must be completed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8628701										
REG. NO.																						
1- FOR STATE REGISTRAR			2a. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2b. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
			Emma									Boos			10/18/86						2340 P.M.	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			8. IF UNDER 74 HRS							
Female			White			MONTH DAY YEAR			81			MONTHS DAYS			HOURS MIN.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			Cecil			MD.							
Germany			U.S.A.			October 8, 1905																
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY													
Elkton			Union Hospital of Cecil County			Housewife																
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			305 King Street 21921							
Maryland			Cecil			Elkton																
14. FATHER'S NAME			LAST			15. MOTHER'S MAIDEN NAME																
FIRST Adam			MIDDLE Glass			FIRST Susanna						LAST Kehder										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS													
No			147 38 0691			Caroline Berman, 305 King St., Elkton, Md 21921																
18. CAUSE OF DEATH: (Enter only one cause per line for 1a, 1b, and 1c.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
Metastatic Cancer of Pancreas																						
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b)																						
DUE TO, OR AS A CONSEQUENCE OF (c)																						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.																						
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?													
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from 10-18, 1986, to OCT 1, 1986, that (I) (we) lost saw the deceased alive on 10-18, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																						
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED													
Madhu S. Sachdev MD												10/19/86										
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			31. main st. North East, Md. 21901																
Madhu S. Sachdev																						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY STATE										
Burial			10/22/86			Graceland Mem. Park			Kenilworth Union			N. J.										
24. FUNERAL DIRECTOR			Ralph E. Hicks			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE													
			Hicks' Home for Funerals, Elkton, Md.			OCT 22 1986																

10018-00

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN LINE 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

28906
REG. NO.

1- STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)						FIRST		MIDDLE		LAST		2a DATE KNOWN <input checked="" type="checkbox"/> OF ESTI- DEATH MATED <input type="checkbox"/>		MONTH	DAY	YEAR	2b HOUR	
		Christopher T. Brewster												<input checked="" type="checkbox"/> 10/22/86		10/22/86	AM	11:06		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.		MONTH DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD		MONTH DAY YEAR		2d. HOUR		
Male		White		June 22, 1986		YRS.		4						<input checked="" type="checkbox"/> 10/22/86				11:06 AM		
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?						8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
Maryland		U.S.A.												Cecil County, MD.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)						12b. KIND OF BUSINESS OR INDUSTRY						
Elkton		Union Hospital of Cecil County						337 Hollingsworth Manor												
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS												
Maryland		Cecil		Elkton		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		337 Hollingsworth Manor 21921												
14. FATHER'S NAME		FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME												
Thomas						Sorrell		Carmencita												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT						ADDRESS										
No										Manor, Elkton, Md.										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		CARMENCITA BREWSTER, 337 HOLLINGSWORTH						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
PART 1 DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a) Sudden Infant Death Syndrome																		
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.		DUE TO, OR AS A CONSEQUENCE OF																		
(b)		DUE TO, OR AS A CONSEQUENCE OF																		
(c)																				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b)																				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?												
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION																
				STREET						CITY OR TOWN		COUNTY		STATE						
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/>						and in my opinion												
ACTUAL SIGNATURE		M.D. Assistant MEDICAL EXAMINER						TITLE (SPECIFY)						DATE SIGNED		10/23/86				
EXAMINER'S NAME (TYPE OR PRINT)		Gregory R. Kauffman, M.D.						ADDRESS						111 Penn St.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION		CITY OR TOWN		COUNTY		STATE								
Burial		10/25/86		Gilpin Manor Mem. Park		Elkton				Cecil		Md.								
24. FUNERAL DIRECTOR		NAME						25a. DATE REC'D. BY REGISTRAR						25b. REGISTRAR'S SIGNATURE						
		Becky E. Hicks						OCT 27 1986												
DMMH - 17 (VR A15 ME (5))																				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached to use as the burial permit. Then please remove carbon patient, page 1, and send it back within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, in medical certification, attach a separate sheet.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 6 2 8 7 0 9					
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
Lee W. Conner						October 13, 1986						7:50AM			
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			
Male			White			MONTH DAY YEAR			77			MONTHS DAYS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			YRS.			IF UNDER 24 HRS.			
Copper Hill, Va.			U.S.A.			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						MONTHS HOURS MIN.			
9. BALTIMORE CITY OR COUNTY OF DEATH						9. BALTIMORE CITY OR COUNTY OF DEATH			Cecil Co			MD.			
11. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Perry Point, Md.			Perry Pt. V.A. Hospital			Machinist, Retd.			BLACK & Dkr. Co						
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE			
Maryland			Baltimore			Perry Hall			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			3852 Schroeder Ave. 21128			
14. MOTHER'S NAME			15. MOTHER'S MAIDEN NAME												
FIRST MIDDLE LAST			FIRST MIDDLE LAST												
Jasper			Elizabeth									Boles			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS						
yes			W W II			231 03 5417			VAMC, PERRY POINT, MD. 21902						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic cardio vascular disease</u>															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Rheumatoid arthritis</u>															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE		
22a. I certify that (X) this hospital attended the deceased from 9/30, 19 86, to 10/13, 19 86, that (X) (we) last saw the deceased alive on 10/13, 19 86, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) did (did not) view the body after death.										22b. SIGNATURE <u>R. Rayson</u> DEGREE				22c. DATE SIGNED 10/13/86	
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>															
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS												
GLENDON RAYSON M. D.			VAMC, Perry Point, Md. 21902												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			23e. COUNTY			
Burial			10-17-1986			St. Michael Luth Ch. Cem. Perry Hall, Balto. Md.									
24. FUNERAL DIRECTOR NAME <u>LASSAHN FUNERAL HOME</u> ADDRESS <u>11750 Belair Rd, Kingsville</u>										25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <u>OCT 15 1986</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove carbon papers. Pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be sent to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be informed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 6 2 8 9 1 0			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
John Patrick Cooney						October 16, 1986			11:50P M				
3. SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
Male		White		July 9, 1909			77			YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.			
Penns.		U.S.A.					Cecil Co.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Perry Point, Md.		VA Medical Center		Retired			Military						
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			
Maryland		Charles		Waldorf						20601 Box 260 E Stavors Rd.			
14. FATHER'S NAME FIRST		MIDDLE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
Michael				Annie Foy									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT (Daughter) ADDRESS									
Yes AirForce 1933-1955		193 30 4483 A		Barbara Ann Farr Same as # 13									
18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE 1a) Cardiopulmonary arrest													
DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia													
Conditions, if any, which gave rise to immediate cause 1a, stating the underlying cause last.													
DUE TO, OR AS A CONSEQUENCE OF (c) Alzheimer's disease													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Colon cancer													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from November 27, 1985, to October 16, 1986, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on October 16, 1986, and that in <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> view the body after death.													
22b. SIGNATURE Kevin M. Miller MD		22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22d. DATE SIGNED 10/17/86					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KEVIN M. MILLER, M.D.		22e. ADDRESS VA Medical Center, Perry Point, MD											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/20/86		23c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cem.			23d. LOCATION Carverton Luzerne Penna.						
24. FUNERAL DIRECTOR NAME Fleming Funeral Service Benson, Md.		ADDRESS 21018			25a. DATE REC'D. BY REGISTRAR OCT 20 1986			25b. REGISTRAR'S SIGNATURE					
DHMH - 16 60M 7/84 (VRA 15, 4)													

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 387

1-
FOR
STATE
REGISTRAR

00-21743			NELSON LEROY CULLUM										SR.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			20. DATE KNOWN OF ESTI- DEATH MATED					
3. SEX m			4. RACE CAUC.			5. DATE OF BIRTH MONTH 7 DAY 17 YEAR 31			6. AGE IN YEARS (LAST BIRTHDAY) 55 YRS.			IF UNDER 1 YR. MONTHS 0			IF UNDER 24 HRS. DAYS 0		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? USA			8			9			21. DATE PRONOUNCED DEAD 10 19 86					
10. CITY OR TOWN OF DEATH ELKTON			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED			12b. KIND OF BUSINESS OR INDUSTRY REIGTH CO.								
13a. STATE MD			13b. COUNTY CECIL			13c. CITY OR TOWN ELKTON			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 195 ADLER 21921					
14. FATHER'S NAME FIRST PAUL			MIDDLE ELMER			LAST COOMBS			15. MOTHER'S MAIDEN NAME FIRST NORA			MIDDLE MAE			LAST CULLUM		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 212 26 6336			17. INFORMANT MRS. BEVERLY J. CULLUM			ADDRESS SAME AS #13e								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial INFARCTION												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 min.					
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost.			DUE TO, OR AS A CONSEQUENCE OF														
(b)			DUE TO, OR AS A CONSEQUENCE OF														
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 Hx of aneurysm of aorta																	
19a. DATE OF OPERATION N/A			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? N/A						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Reginald W. Stallings, M.D.</i>						TITLE (SPECIFY) M.D.			MEDICAL EXAMINER			DATE SIGNED 10/19/86					
EXAMINER'S NAME (TYPE OR PRINT) REGINALD W. STALLINGS			ADDRESS 6716 YATHREBA, BALTO. MD			23a. NAME OF CEMETERY OR CREMATORIAL (SPECIFY) CALVARY			23b. LOCATION CITY OR TOWN CALVARY, HARFORD CO.			23c. LOCATION CITY OR TOWN MARYLAND					
23d. DATE 28 OCTOBER 86			23e. DATE REC'D. BY REGISTRAR OCT 25 1986			24. FUNERAL DIRECTOR NAME MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MD. 21078			25a. DATE REC'D. BY REGISTRAR OCT 25 1986								
BP _____																	
DHMH-17 (VA15 ME (5)) 15M 2/80																	

84518-10

1870

00-20775

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and countersigned by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. This certificate should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8628912	
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
			Samuel G. Davis						October 5, 1986			3:00A M	
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS	
Male			White			July 2 1920			66 YRS.			IF UNDER 24 HRS HOURS MIN.	
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Maryland			U.S.A.						Cecil MD.			12b. KIND OF BUSINESS OR INDUSTRY	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13e. STREET ADDRESS / ZIP CODE			21902	
Perry Point			Vet. Adm. Medical Center			13b. STATE Maryland 13c. COUNTY Cecil 13d. CITY OR TOWN Perry Point			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE	
14. FATHER'S NAME FIRST			15. MOTHER'S MAIDEN NAME FIRST									LAST	
Samuel			Emma									Loller	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Yes WW II			222 01 5356			David P. Davis, Elkton, Md.						21921	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) Chronic renal failure													
DUE TO, OR AS A CONSEQUENCE OF (b) Cirrhosis of the liver													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
DUE TO, OR AS A CONSEQUENCE OF (c) Esophageal varices													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from 4-15- 1986, to 10-5- 19 86, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 10-5- 19 86, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did <input type="checkbox"/> view the body after death.												22c. DATE SIGNED	
22b. SIGNATURE Michael Taylor, M.D.												22c. DATE SIGNED 10-5-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>							
MICHAEL TAYLOR, M.D.			VAMC, Perry Point, Maryland										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY	STATE
Burial			10/7/86			Bethel Cemetery			Chesapeake City, Cecil, Md.				
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
Joseph S. Hicks			Hicks Funeral Home, Elkton, Maryland			OCT 14 1986							

31705-00



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon slips, page 1 and 3, and file within 72 hours after death with the State Dept. of Health and Mental Hygiene either to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on page 2, show any injury, or other traumatic event, die medical examiner must be advised.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH																	
3 0 2 8 9 1 3																	
REG. NO.																	
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR								
LILLIAN D DEHRENBACH						10 26 88			9:47 AM								
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.					
F female		White		Dec. 29 1917			68 YRS.										
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH										
Maryland		U.S.A.					Cecil			MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY										
Elkton		Union Hospital of Cecil County					Production Line			Clothing Mfg							
13a. STATE 13b. COUNTY 13c. CITY OR TOWN												13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE		
Maryland		Cecil		Elkton			140 Friendship Rd. 21921										
14. FATHER'S NAME FIRST		MIDDLE		LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST										
Howard		O.		Donnelly			Mary Irene Canon										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			APPROPRIATE INTERVAL BETWEEN ONSET AND DEATH							
No		216 10 2012		Barbara Brock, Chesapeake City, Md. 21915			Acute Respiratory Failure										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		DUE TO, OR AS A CONSEQUENCE OF (b) Acute / Chronic Congestive Heart Failure			DUE TO, OR AS A CONSEQUENCE OF (c) Secondary to Coronary Artery Disease												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE				
22a. I certify that (I) (the hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on 10/26/86 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 10/26/86					
22b. SIGNATURE Jayantilal K. Patel		22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAYANTILAL K. PATEL MD			22e. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 10/29/86		23c. NAME OF CEMETERY OR CREMATORIAL Bethel Cemetery			23d. LOCATION CITY OR TOWN Chesapeake City Cecil Md.										
24. FUNERAL DIRECTOR NAME Hicks Home for Funerals,		25a. DATE REC'D. BY REGISTRAR OCT 20 1988			25b. REGISTRAR'S SIGNATURE R. Hicks												

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers, pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If Item 21 is marked at Item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

28

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I. DECEASED NAME (TYPE OR PRINT)			MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	REG. NO.		
Michael NMI			DeROSE		October 5, 1986			2b. HOUR 12:05A M			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH OCTOBER DAY 22 YEAR 1921		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CECIL COUNTY		MD			
10. CITY OR TOWN OF DEATH Perry Point, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN 10, SPECIFY, GIVE STREET ADDRESS) VA Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TAYLOR		12b. KIND OF BUSINESS OR INDUSTRY CLOTHING					
13a. STATE MD		13b. COUNTY CECIL		13c. CITY OR TOWN EKLTN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 236 E. MAIN STREET 21918			
14. FATHER'S NAME FIRST ANTHONY		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME LENA		MIDDLE		LAST		FIORE	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. WW II		17. INFORMANT VAMC, Perry Point, Maryland		ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ca of bladder with metastasis</u>											
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Renal failure</u>											
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>10-3-86</u> , 19 <u>86</u> , to <u>10-5</u> , 19 <u>86</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>10-5</u> , 19 <u>86</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did not touch the body after death.											
22b. SIGNATURE <u>Michael Taylor, M.D.</u>		22c. DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22d. DATE SIGNED 10-5-86					
22e. PHYSICIAN'S NAME MICHAEL TAYLOR, M.D.		22f. ADDRESS VAMC, Perry Point, Maryland									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8 OCTOBER 86		23c. NAME OF CEMETERY OR CREMATORIAL QUANTICO NAT. CEMETERY		23d. LOCATION CITY OR TOWN QUANTICO		COUNTY		STATE VIRGINIA	
24. FUNERAL DIRECTOR NAME Mitchell Funeral Home, Havre de Grace, Md.		ADDRESS		25a. DATE REC'D. BY REGISTRAR OCT 09 1986		25b. REGISTRAR'S SIGNATURE					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and simplified filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove section **General Information** and **Section 2** should be filled within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The

MEDICAL CERTIFICATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR
STATE
REGISTRATION

I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
HOMER M. DUNBAR						October 14, 1986			8:50am			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Male		Caucasian		February 19, 1918			68 YRS			IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
Pennsylvania		U.S.A.					Cecil County					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Perry Point, Md.		VA Medical Center		Technician			Refinery (Oil)					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE	13b. COUNTY	13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE				
Maryland	Cecil	Earlville						13 Roberts Street /21919				
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST				
Mitchell		V.	Dunbar	Hazel			M.	Smith				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Yes		WW II		178-07-4754			Mrs. Patricia M. Noland, Newark, Delaware					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) Cardiopulmonary arrest												
DUE TO, OR AS A CONSEQUENCE OF (b) Metastasic carcinoma of lungs												
DUE TO, OR AS A CONSEQUENCE OF (c) _____												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE				
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from August 18 , 19 86 to October 14 , 19 86 XXXXXXXXXX , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>John Lonergan</i>		22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22d. DATE SIGNED 10-14-86				
22e. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN LONERGAN, M.D.		22f. ADDRESS VA Medical Center, Perry Point, Md.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 10/17/86		23c. NAME OF CEMETERY OR CREMATORIUM Bethel Cemetery			23d. LOCATION CITY OR TOWN			23e. DATE REC'D. BY REGISTRAR 1986		
24. FUNERAL DIRECTOR <i>Spicer Funeral Home, Perry Point, DE.</i>		25. ADDRESS <i>Warwick General Hospital, Warwick, DE.</i>		# 016			CITY OR TOWN			COUNTY STATE		
26. DATE REC'D. BY REGISTRAR OCT 20 1986												

03455-0

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and certified by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 4 and this page should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked (X) show any injury, or other traumatic event, if present, on item 22.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
8 6 2 8 7 1 0 REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			2a. DATE OF DEATH MONTH DAY YEAR		
John B. Dunn									October 25, 1986		
3. SEX Male			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR 10-31-29			6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) UNK			7b. CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.		
10. CITY OR TOWN OF DEATH Perry Point			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Perry Point V.A.M.C.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) UNK			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland			13b. COUNTY P.G.			13c. CITY OR TOWN Cap. Hgts.			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST UNK						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNK					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. WW II 577 32 7609			17. INFORMANT Perry Point VAMC			ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe metabolic & Respiratory acidosis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
DUE TO, OR AS A CONSEQUENCE OF (c) Chronic obstructive pulmonary disease											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Alcoholism; Organic brain syndrome, Diabetes mellitus, insulin dependent											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (X) (this hospital) attended the deceased from October 20, 1986 to October 25, 1986, that <input checked="" type="checkbox"/> (X) (we) last saw the deceased alive on October 25, 1986, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (X) (we) did <input checked="" type="checkbox"/> (X) (X) (X) view the body after death.											
22b. SIGNATURE Glendon Rayson			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 10-25-86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GLENDON Rayson, M.D.			22e. ADDRESS VA Medical Center, Perry Point, MD 21902								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal/Burial			23b. DATE 10/31/86			23c. NAME OF CEMETERY OR CREMATORIAL Culpeper National			23d. LOCATION CITY OR TOWN COUNTY STATE Culpeper, Culpeper, Virginia		
24. FUNERAL DIRECTOR NAME Tarring Funeral Home, PA, Aberdeen, MD, 21001-3399			25a. DATE REC'D. BY REGISTRAR ADDRESS			25b. REGISTRAR'S SIGNATURE					

45555-00

A01

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH														
8 6 2 8 7 1 1											REG. NO.			
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
Irvin Albert Fischer									October 14, 1986			2:25 A.M.		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male		White		Dec. 6, 1921			64		MONTHS DAYS		HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8			9. BALTIMORE CITY OR COUNTY OF DEATH			MD			
Baltimore, MD		USA			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Cecil County						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Perry Point, Md.		VA Medical Center						Truck Driver						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE					
Maryland		AA		Severn					1114 Reece Road			21144		
14. FATHER'S NAME FIRST		MIDDLE		LAST			15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST			
Frederick				Fischer			Elsa				Klonte			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS						
Yes		WW II			214 14 1953			VAMC, Perry Point, Maryland			Same as 13 Mary Fischer			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
F Conditions, if any, which give rise to immediate cause (a), stating the underlying cause, lost. (b), (c)														
DUE TO, OR AS A CONSEQUENCE OF														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. MEDICAL CERTIFICATION		Huntington's Chorea			19b. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
											YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8-1- 19 86, to 10-14- 19 86, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 10-14- 19 86, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> view the body after death.												22c. DATE SIGNED 10-14-86		
22b. SIGNATURE <i>John Lonergan</i>		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/>			MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input checked="" type="checkbox"/>				
22e. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN LONERGAN, M.D.		22f. ADDRESS VAMC, Perry Point, Maryland												
23a. BURIAL, CREMATION, REMOVAL (SPECIES)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL Meadowridge Mem. Pk.			23d. LOCATION CITY OR TOWN Elkridge		COUNTY Howard		STATE MD			
Burial		Oct. 17, 1986												
24. FUNERAL DIRECTOR NAME Kirkley Funeral Home, Glen Burnie, Md.		ADDRESS			25a. DATE REC'D. BY REGISTRAR OCT 16 1986			25b. REGISTRAR'S SIGNATURE						

1

TO HOSPITAL OR ATTENDING PHYSICIAN. The letter is to be submitted by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached from the burial transit permit. Then placed in one of the carbon copies. Pages 1 and 2 should be held within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

With the Space Derby, students learn about the engineering and design process, as well as the principles of flight and aerodynamics.

MEDICAL CERTIFICATION

**1 - STATE
REGISTRAR**

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

28

I. DECEASED NAME (TYPE OR PRINT) CECIL C FITZPATRICK			2a. DATE OF DEATH OCTOBER 6, 1986			2b. HOUR 6:30 P.M.		
3. SEX MALE	4. RACE CAUC.	5. DATE OF BIRTH MONTH 02 DAY 04 YEAR 1907	6. AGE (IN YEARS LAST BIRTHDAY) 79			IF UNDER 1 YEAR MONTHS YRS. DAYS 00 HOURS 00 MIN. 00		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA.	7b. CITIZEN OF WHAT COUNTRY? U.S.S.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH CECIL COUNTY			MD		
10. CITY OR TOWN OF DEATH PERRY POINT, MD.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA MEDICAL CENTER			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY AUTO SALES	
13a. STATE MARYLAND		13b. COUNTY BALTIMORE	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 7581 WESTFIELD ROAD 21222			
14. FATHER'S NAME FIRST THOMAS MIDDLE LAST FITZPATRICK		15. MOTHER'S MAIDEN NAME FIRST LAURA MIDDLE LAST SMITH						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. WW II 164 09 6320	17. INFORMANT VAMC, Perry Point, Maryland	ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:								
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. 19 DAY 19 YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2) XX						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) XX	21f. LOCATION STREET XX	CITY OR TOWN XX	COUNTY XX	STATE XX			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from September 29, 1986 to October 6, 1986 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on October 6, 1986 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (try to) view the body after death.								22c. DATE SIGNED 10-6-86
22b. SIGNATURE MAHMUT N. ATAY, M.D.		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input checked="" type="checkbox"/>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MAHMUT N. ATAY, M.D.		22e. ADDRESS VA MEDICAL CENTER, PERRY POINT, MD.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 10/09/86	23c. NAME OF CEMETERY OR CREMATORIAL HOLLY HILLS	23d. LOCATION CITY OR TOWN BALTIMORE, MD.	23e. COUNTY XX	STATE XX			
24. FUNERAL DIRECTOR NAME DAROWSKI FUNERAL HOME, Dundalk, Maryland		ADDRESS XX		25a. DATE REC'D. BY REGISTERED MAIL OCT 14 1986				

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 8 9 1 9

1 - FOR
STATE
REGISTRAR

REG. NO.

00-20346

1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
				Hilda	B.	Gifford	Oct. 3	1986			10:50a.m.		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.	
Female		White		March 1, 1903			83 YRS						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
Middletown, Del.		U.S.					Cecil						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			Education			
Rising Sun		Calvert Manor Nursing Home, Inc.					School Teacher						
13a. STATE Maryland		13b. COUNTY Cecil		13c. CITY OR TOWN Rising Sun		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1169 Calvert Road		21911			
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST			
William				Henry Boulden		Mary		Jane		Conner			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
No				212-38-4292		Ralph Gifford, Box 2, Intercourse, PA 17534							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO, OR AS A CONSEQUENCE OF													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <u>Chronic Renal Failure, Anemia</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>July 1, 1975</u> to <u>October 3, 1986</u> , that (I) (we) last saw the deceased alive on <u>September 10, 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE		22c. DEGREE		22d. ATTENDING PHYSICIAN		22e. MEDICAL DIRECTOR		22f. STAFF PHYSICIAN		22g. DATE SIGNED			
Charles B. Hengen M.D.										Oct. 8, 1986			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE			
Burial		Oct. 5, 1986		Friends Cem.		Calvert Cecil Md.							
24. FUNERAL HOME NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Intercourse Funeral Home North East, Md.				OCT 08 1986		Ralph Gifford							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed within 72 hours after death. The medical examiner can review this certificate with the State Dept. of Health and Mental Hygiene prior to burial or removal.

IMPORTANT: If Item 21 is marked "NO", then any injury or illness that may have contributed to death should be marked "YES".

00-30398



0-21408

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon paper. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 20 shows any injury, or other traumatic event, the in-

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 6 2 8 9 2 0		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST		20. DATE OF DEATH	MONTH	DAY	YEAR	20. HOUR	
HELEN			6.	GIOVAN			10	9	86		1200 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female		CAUC.		MONTH DAY YEAR		64		MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.				
Phila PA		USA		Dec 15 1921		CECIL						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY		
EARLEVILLE		169 PARK DRIVE				SALESCLERK				RETAIL SALES		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE				
MARYLAND		CECIL		EARLEVILLE				169 PARK DRIVE 21919				
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		16. ADDRESS				LAST	
JOHN				CONWAY	LAURA		HARRY GIOVAN JR HUSBAND SAME				SCHAEFFER	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
NO		N/A		179-14-7362		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				cardiopulmonary collapse minutes		
						DUE TO, OR AS A CONSEQUENCE OF (b) metastatic carcinoma				months		
						DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, _____)												
22b. SIGNATURE Robt. Denitzio		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/9/86						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robt. Denitzio MD		22e. ADDRESS Cecil-Kent Health Center								CECILTON MD.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 10-12-86		23c. NAME OF CEMETERY OR CREMATORIAL BETHEL CEM.		23d. LOCATION CITY OR TOWN ches. City		COUNTY Cecil		STATE MD		
24. FUNERAL DIRECTOR NAME Fellows F. H. E. MAIN ST. CECILTON MD.		25a. DATE REC'D. BY REGISTRAR 219 OCT 16 1986				25b. REGISTRAR'S SIGNATURE						
ADDRESS												

90-18

1900

1900

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TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached from this certificate and placed in the carbon copies. Pages 1 and 2 should be filed within 24 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, an other traumatic event, the medical examiner may be retained.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	6	28	42
												REG. NO.			
1 - FOR STATE REGISTRAR	1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
	RAYMOND C. HANCE						October 15, 1986						5:10am		
3. SEX	4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male	White			October 25, 1918			67			MONTHS	YEARS	MONTHS	HOURS	MIN.	
10 BIRTHPLACE STATE OR FOREIGN COUNTRY	7b. CITIZEN OF WHAT COUNTRY?			8.			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
Maryland	USA			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Cecil								
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION TYPE OF WORK FOR MOST OF WORKING LIFE			12b. KIND OF BUSINESS OR INDUSTRY								
Perry Point, Md.	VA Medical Center			heavy equipment operator			U.S. govt								
13a. STATE	13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS, ZIP CODE							
Md	Prince George		Laurel		NO			14440 Bowie Road 20708							
14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST								
J. Franklin Hance			Stella				Slade								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS								
yes	WW 2			212-18-9719			May Hance same as above								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestion & edema of lungs, marked															
DUE TO, OR AS A CONSEQUENCE OF (b) Cyanosis, marked															
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last.															
DUE TO, OR AS A CONSEQUENCE OF (c) Cirrhosis of liver, micronodular, advanced															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE				
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from October 9, 1986, to October 15, 1986, <input checked="" type="checkbox"/> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 10-15-86			
22b. SIGNATURE Avelina C. Hernandez		22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input checked="" type="checkbox"/>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			VA Medical Center, Perry Point, Md.										
AVELINA HERNANDEZ, M.D.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct 18, 1986		23c. NAME OF CEMETERY OR CREMATORIAL Fort Lincoln Cem			23d. LOCATION CITY OR TOWN Brentwood, Maryland		COUNTY	STATE					
24. FUNERAL DIRECTOR NAME Donaldson Funeral Home, Laurel, Md.		25. DATE REC'D. BY REGISTRAR Oct 2, 1986			25. REGISTRAR'S SIGNATURE										
BP															
DHMH - 16 60M 7/84 (VRA 15, 4)															

2083-0

AGE CONVERGENCE

100 200 300

023469 NOV 30 1986
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed with the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove certificate from pages 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or interment.

IMPORTANT: If item 21 is marked on item 18, it shows any injury or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						8628722			
				REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	20. HOUR
<i>Margaret</i>		<i>J.</i>		<i>Hollis</i>	<i>Oct.</i>	<i>30</i>	<i>1986</i>		<i>M</i>
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS	
<i>Female</i>		<i>White</i>		<i>Sept. 9 1898</i>		<i>88</i>		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
<i>New York</i>		<i>U.S.A.</i>				<i>CECIL</i>			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
<i>Elkton</i>		<i>24 Knollwood Road</i>		<i>Housewife</i>					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS	
<i>Maryland</i>		<i>Cecil</i>		<i>Elkton</i>		<i>24 Knollwood Road</i>		<i>21921</i>	
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	
<i>William</i>				<i>Seeger</i>		<i>Margaret</i>		<i>Klemp</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
<i>No</i>		<i>216 09 3252</i>		<i>Mrs. Lorris R. Clay, 24 Knollwood</i>		<i>21921</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CONGESTIVE HEART FAILURE</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
DUE TO, OR AS A CONSEQUENCE OF (b) <i>ARTERIAL SCLEROTIC CARDIOVASCULAR DISEASE</i>									
DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>1-11</i> , 19 <i>67</i> , to <i>10-30</i> , 19 <i>86</i> , that (I) (we) last saw the deceased alive on <i>10-28</i> , 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Rolando A. Najera</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>10-30-86</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
<i>Dr. Rolando A. Najera, M.D.</i>		<i>105 E. Main Street, Elkton, Md 21921</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORI		23d. LOCATION CITY OR TOWN		COUNTY STATE	
<i>Burial</i>		<i>Nov. 3, 1986</i>		<i>Gilpin Manor Mem. Pk.</i>		<i>Elkton</i>		<i>Cecil Md.</i>	
24. FUNERAL DIRECTOR <i>Ralph E. Hicks</i>		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Readback</i>			
<i>Hicks Home for Funerals</i>		<i>Elkton, Md.</i>		<i>NOV - 7 1986</i>					

26.01.2013 20:25:00

2013-01-26 20:25:00

2013-01-26 20:25:00

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 20 days of the death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the bottom master permit. Then please remove carbon paper. Pages 1 and 2 should be retained within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or items 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH3 6 2 8 9 2 3
REG. NO.

00-21658

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR					
LEROY					JENNINGS	October	20	1986	2:37 a.m.						
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.					
Male		Black		Feb. 14, 1917		69		YRS.							
7a. PLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County									
Florida		USA													
10. CITY OR TOWN OF DEATH Perry Point, MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Night Watchman		12b. KIND OF BUSINESS OR INDUSTRY ----									
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Pa.		14. COUNTY Delaware	15. CITY OR TOWN Philadelphia	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6030 Cedar Ave. 19131									
16a. FATHER'S NAME FIRST Eccelia		MIDDLE	LAST Jennings	15. MOTHER'S MAIDEN NAME FIRST Flora		MIDDLE	LAST Walters								
16b. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16c. SOCIAL SECURITY NO. 1944-1946		17. INFORMANT VA Medical Records, VAMC Perry Point		ADDRESS									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Carcinoma of Lung													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
(b) Bronchopneumonia, acute & organizing, LLL															
DUE TO, OR AS A CONSEQUENCE OF (c) Miliary nodules mainly in lower lobe of right															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION STATED IN PART 1 (o)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21d. INJURY OCCURRED NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from October 12, 1986, to October 20, 1986, XXXXXXXXXX, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, mark here.)															
22b. SIGNATURE Roy W. Chestnut, Jr. M.D.		DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR		STAFF PHYSICIAN		22c. DATE SIGNED 10/20/86					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROY CHESTNUT, M.D.		22e. ADDRESS VA Medical Center, Perry Point, MD													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 25, 1986		23c. NAME OF CEMETERY OR CREMATORIAL Glenwood Gardens		23d. LOCATION CITY OR TOWN Bromall		COUNTY Delaware		STATE Pa.					
24. FUNERAL DIRECTOR Lee A. Patterson & Son, Perryville, Md.		25a. DATE REC'D. BY REGISTRAR OCT 21 1986		25b. REGISTRAR'S SIGNATURE											

999 999
BP

36819-00

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM, PAGE 3, WHICH CONTAIN PAGE 5 FOR YOUR FILES. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM, PAGE 3, WHICH CONTAIN PAGE 5 FOR YOUR FILES. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM, PAGE 3, WHICH CONTAIN PAGE 5 FOR YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 28924			
1- STATE REGISTRAR			I. DECEASED NAME FIRST <i>Nora</i> MIDDLE <i>Mae</i> LAST <i>Johnson</i>									2a DATE KNOWN OF ESTI- DEATH MATED <i>X 10 11 1986</i>			
2. SEX <i>Female</i>			4. RACE <i>White</i>		5. DATE OF BIRTH MONTH <i>MAY</i> DAY <i>12</i> YEAR <i>1914</i>		6. AGE (IN YEARS) LAST BIRTHDAY <i>72</i> YRS		7. IF UNDER 1 YR. MONTHS <i>0</i> DAYS <i>0</i>		8. IF UNDER 24 HRS. HOURS <i>0</i> MIN <i>0</i>		2b HOUR <i>2d 10 12 1986 6:15A</i>		
9. BIRTHPLACE STATE OR FOREIGN COUNTRY <i>MARYLAND</i>			10. CITIZEN OF WHAT COUNTRY? <i>USA</i>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Cecil County MD.</i>										
10. CITY OR TOWN OF DEATH <i>ELKTON</i>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SAME FACILITY, GIVE STREET ADDRESS) <i>10 Pine Avenue</i>									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>HOMEMAKER</i>			
13a. STATE <i>MD</i>			13b. COUNTY <i>CECIL</i>		13c. CITY OR TOWN <i>ELKTON</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <i>X</i>		13e. STREET ADDRESS <i>21921 10 PINE AVENUE (WHISPERING PINE T.P.)</i>						
14. FATHER'S NAME FIRST <i>HARRY</i> MIDDLE <i>WINFIELD</i> LAST <i>CULLUM</i>			15. MOTHER'S MAIDEN NAME FIRST <i>SARAH</i> MIDDLE <i>JANE</i> LAST <i>THOMPSON</i>												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>NO</i>			16b. SOCIAL SECURITY NO. <i>217 26 7525</i>		17. INFORMANT <i>THOMAS C. JOHNSON</i> ADDRESS <i>SAME AS #13e</i>										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic cardiovascular disease</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> lying cause last.															
DUE TO, OR AS A CONSEQUENCE OF (b) _____															
DUE TO, OR AS A CONSEQUENCE OF (c) _____															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1-a. <i>Diabetes Mellitus</i>															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <i>X</i>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE			
22a. I certify that I took charge of the remains described above, held on <i>Autopsy</i> <input type="checkbox"/> <i>Inspection</i> <input checked="" type="checkbox"/> <i>Inquiry</i> <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <i>J. C. Gonzalez-Vitale, M.D.</i>			TITLE (SPECIFY) <i>M.D.</i> Deputy MEDICAL EXAMINER									DATE SIGNED <i>10-12-86</i>			
EXAMINER'S NAME (TYPE OR PRINT) <i>Juan C. Gonzalez-Vitale, M.D.</i>			ADDRESS <i>Union Hosp., Elkton MD 21921</i>												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>			23b. DATE <i>15 OCTOBER 86</i>		23c. NAME OF CEMETERY OR CREMATORIAL CALVARY METHODIST CEMETERY				23d. LOCATION CITY OR TOWN <i>CALVARY</i>		COUNTY <i>HARFORD CO.</i>	STATE <i>MARYLAND</i>			
24. FUNERAL DIRECTOR NAME <i>Mitchell Funeral Home PA</i>			25a. DATE REC'D. BY REGISTRAR <i>OCT 15 1986</i>									25b. REGISTRAR'S SIGNATURE <i>J. C. Gonzalez-Vitale</i>			
ADDRESS <i>Havre de Grace, MD 21078</i>															

11015-0

28-1-21 X

roundish with cavity

28-1-21

25 mm in diameter

smooth base

X

smooth surface

smooth surface

smooth surface

X

X

28-1-21

fragile

dark

12-1-21 (Continued, 9th note) on 3rd specimen I noted

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon paper and remove with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked **other**, show any injury, or other trauma.

MEDICAL CERTIFICATION

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 2 8 7 2 5
REG. NO.

1. DECEASED NAME FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Osa Letts			Oct. 3, 1986	5:30 A.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH Mar. 3, 1986	6. AGE (IN YEARS LAST BIRTHDAY) 66	IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Cecil	
10. CITY OR TOWN OF DEATH Elkton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SAME FACILITY, GIVE STREET ADDRESS) Union Hospital			12a. USUAL OCCUPATION Homemaker
13a. STATE Md.	13b. COUNTY Cecil	13c. CITY OR TOWN North East	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS, ZIP CODE 24 Rolling Mill La. 21901
14. FATHER'S NAME FIRST MIDDLE LAST Harry Wharton	15. MOTHER'S MAIDEN NAME Carrie Bryan			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN) No	16b. SOCIAL SECURITY NO. 214-18-0294	17. INFORMANT David E. Letts	24. ADDRESS Rolling Mill La. North East, Md. 21901	25. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Resp. failure.</i>				
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cancer of R.</i> lung				
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <i>M. Sachdev</i>	DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. M. SACHDEV	22e. ADDRESS 3 N. MAIN ST., NORTH EAST, MD. 21901	22c. DATE SIGNED 10/7/86		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 10-6-86	23c. NAME OF CEMETERY OR CREMATORIAL North East Meth. Cem. North East Cecil Md.	23d. LOCATION CITY OR TOWN	COUNTY STATE
24. FUNERAL DIRECTOR NAME Crouch Funeral Home North East	25a. MD. REC'D. BY REGISTRAR OCT 08 1986	25b. REGISTRAR'S SIGNATURE <i>Robert L. Crouch</i>		

00-30343



00-30343

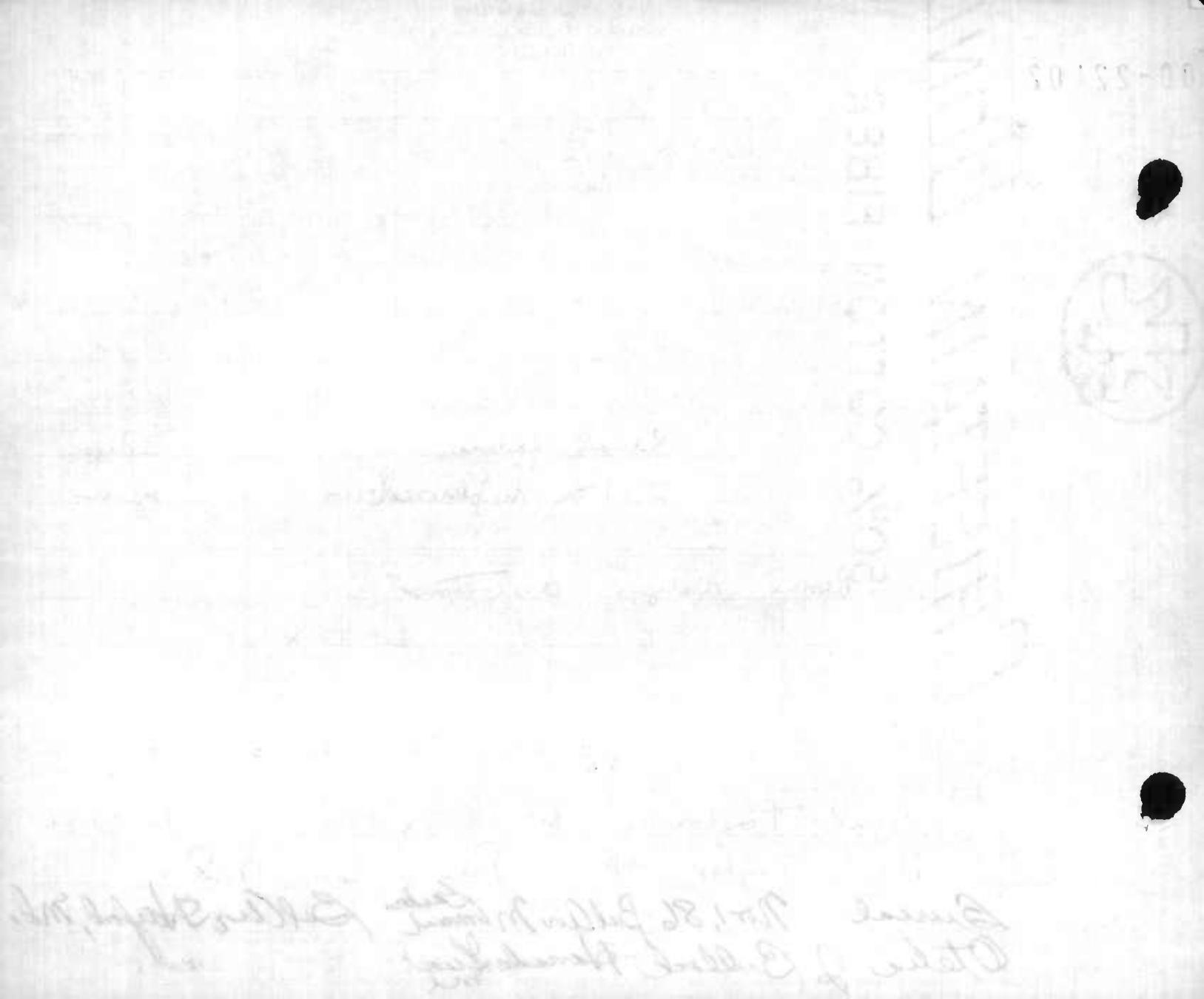
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be submitted within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or physician in charge, it should be detached for use as the burial/transit permit. Then please remove carbon paper from the back of the certificate and attach it with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 18 shows any injury, or other traumatic event, the death certificate should be filed within 72 hours after death.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 3628926		
1 - STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR 10-26-86									2b. HOUR 4:30 PM		
1. DECEASED NAME (TYPE OR PRINT) Sarah E. Lewis			5. DATE OF BIRTH MONTH DAY YEAR 12-23-06			6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS			7. IF UNDER 1 YEAR MONTHS DAYS			8. IF UNDER 24 HRS. HOURS MIN.		
3. SEX Female			4. RACE Black			9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.								
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			10a. USUAL OCCUPATION Housekeeper			11b. KIND OF BUSINESS OR INDUSTRY		
11. CITY OR TOWN OF DEATH Rising Sun			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Calvert Manor Nursing Home			12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13c. STREET ADDRESS / ZIP CODE 213 Franklin St. 21014		
13b. COUNTY Harford			13c. CITY OR TOWN Bel Air			13d. MOTHER'S MAIDEN NAME FIRST may MIDDLE LAST Corns								
14. FATHER'S NAME FIRST Robert			14. MIDDLE Lewis			15. ADDRESS								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 215-32-4452			17. INFORMANT Eula Ruff								
18. CAUSE OF DEATH (Enter only one cause per line for 18a, b, and c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal failure DUE TO, OR AS A CONSEQUENCE OF (b) Diabetes nephroclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (c) years DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. Renal disease discontinued														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE		
22a. I certify that (1) (this hospital) attended the deceased from 10-22, 1986, to 10-26, 1986, that (1) (we) last saw the deceased alive on 10-25, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 10-27-86		
22b. SIGNATURE Neil Taylor			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. ADDRESS					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Neil Taylor MD														
23a. BURIAL, CREMATION, REMOVAL (TYPE) Burial			23b. DATE Nov. 86			23c. NAME OF CEMETERY OR CRYSTAL GARDEN Bel Air Memorial			23d. LOCATION			23e. DATE REC'D. BY REGISTRAR 29		
24. FUNERAL DIRECTOR Otelia J. Bullock												25. REGISTRAR'S SIGNATURE		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 2 should be left within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner may be required to examine the body.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 6 2 3 9 2 1							
											REG. NO.								
1. FOR STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST John			MIDDLE McLain			LAST			2a. DATE OF DEATH October 24, 1986			2b. HOUR 10:55 P.M.	
3. SEX Male			4. RACE Cauc.			5. DATE OF BIRTH MONTH Feb. 25, 1922			YEAR			6. AGE (IN YEARS (LAST BIRTHDAY)) 64			IF UNDER 1 YEAR MONTHS YRS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> XX			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County							
10. CITY OR TOWN OF DEATH Perry Point			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Perry Point V/A Med. Gen.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver			12b. KIND OF BUSINESS OR INDUSTRY Delivery										
13a. STATE Maryland			13b. COUNTY Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 2820 Belmont Ave. 21231										
14. FATHER'S NAME FIRST Jim			MIDDLE McLain			15. MOTHER'S MAIDEN NAME FIRST Lilly			MIDDLE Breeden										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes-Navy			16b. SOCIAL SECURITY NO. 1942-46 250 28 2124			17. INFORMANT (Brother) P.O. Box # 1			ADDRESS Hector McLain Little Rock, S.C. 29567										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			Cardiac arrest											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			(b) Arteriosclerotic heart disease																
			(c)																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																			
Diabetes mellitus, insulin dependent; Chronic obstructive pulmonary disease																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from February 19, 1986, to October 24, 1986, that (X) (we) last saw the deceased alive on October 24, 1986, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (X) (we did) (X) (we did not) view the body after death.																			
22b. SIGNATURE R. Rayson			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 10-25-86										
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GLENDON RAYSON, M.D.			22e. ADDRESS VA Medical Center, Perry Point, MD 21902																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10/29/86			23c. NAME OF CEMETERY OR CREMATORIAL St. Mary's Cem.			23d. LOCATION CITY OR TOWN Dillon			COUNTY		STATE					
24. FUNERAL DIRECTOR NAME FLEMING FUNERAL HOME, Baltimore, MD.			ADDRESS			25a. DATE REC'D. BY REGISTRAR OCT 28 1986			25b. REGISTRAR'S SIGNATURE										

3

TO HOSPITAL OR ATTENDING PHYSICIAN: The

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove carbon paper with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

and completely killed in by the funeral director. ~~post~~ ² hour after death

MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

6 28428
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ELIZABETH Arrants MITCHELL			2a. DATE OF DEATH MONTH 10 5 86	DAY YEAR 86-11:0A.M.	2b. HOUR		
3. SEX F		4. RACE White	5. DATE OF BIRTH MONTH 12 24 1900	6. AGE (IN YEARS LAST BIRTHDAY) 85 yrs -	IF UNDER 1 YEAR MONTHS YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Elkton, Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.			
10. CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Devine Haven Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired-Telephone Operator		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Cecil	13c. CITY OR TOWN Elkton	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 313 W. Main Street	ZIP CODE 21921	
FATHER'S NAME FIRST William		MIDDLE H.	LAST Realey	15. MOTHER'S MAIDEN NAME FIRST Edith Louise Clay			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-05-0322A		17. INFORMANT Edith R. McKeown	ADDRESS 238 Mackall St.	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gangrene of feet							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any. (b) _____							
DUE TO, OR AS A CONSEQUENCE OF Sepsis- Semi-Comatose							
DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes Mellitus, Cerebral Vasculitis							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. 19a. DATE OF OPERATION							
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from 11/5/79 to 10/5/86 , 19, that (I) (we) last saw the deceased alive on 10/1/86 , 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Jayantilal K. Patel MD		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 10/6/86				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAYANTILAL K. PATEL MD		22e. ADDRESS 123 Sinerly Ave, Elkton, MD 21921					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-9-86	23c. NAME OF CEMETERY OR CREMATORIAL Elkton Cemetery	23d. LOCATION CITY OR TOWN Elkton	COUNTY Cecil	STATE Md.	
24. FUNERAL DIRECTOR NAME See Funeral Home P.A.		ADDRESS Elkton, Md.	25a. DATE REC'D. BY REGISTRAR OCT 10 1986		25b. REGISTRAR'S SIGNATURE John R. ...		

2000-01-02

1900-1901. 1902-1903. 1904-1905.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon paper. If item 21a is marked, it should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked and item 18 shows any injury, or other traumatic event, the death certificate should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8628729			
											REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
HELEN					MOORE	October			29	1986	2:35 AM				
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 24 HRS				
Female			White		Aug. 29, 1901			85			MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8			9			YRS.				
New York			U. S. A.		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			BALTIMORE CITY OR COUNTY OF DEATH			MD.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
ELKTON			LAURELWOOD Nursing Center		Housewife			702 LOMBARD Court			1009				
13a. STATE			13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE				
MD.			Harford		Abington						702 LOMBARD Court				
14. FATHER'S NAME FIRST			MIDDLE		15. MOTHER'S MAIDEN NAME FIRST			16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS			LAST	
Andrew					Charlotte			129-10-3321			Helen Nystram			Johnson	
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			18b. (IF YES, GIVE WAR OR DATES)		18c. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			18d. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
ND					Recurrent Cerebral Pneumonia										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			(b)			18e. DUE TO, OR AS A CONSEQUENCE OF Recurrent Cerebral Pneumonia									
			(c)												
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from 13 July 1983 to 10-29-86, 19, that (I) (we) last saw the deceased alive on 26 Oct 1986, and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (I) (We) did not view the body after death.															
22b. SIGNATURE			22c. DEGREE			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED						
22f. PHYSICIAN'S NAME (TYPE OR PRINT)			22g. ADDRESS												
Joseph G. Lanzi			Bridge St. Elkton MD.												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR Crematory			23d. LOCATION CITY OR TOWN			COUNTY	STATE		
Burial			Oct. 31 1986			Cedar Heights			West Milford			Passaic	NJ.		
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
Edward McKeown						Nov 03 1986									
Gee Funeral Home			259 E. Main St. Elkton MD.												

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be submitted within 24 hours of death. Page 4 may be

TO FUNERAL DIRECTOR: After this certificate has been signed by the offending person and completely filled in by the funeral director, page 3 should be detached, or use as the burial-transit permit. Then please remove carbon copy. Page 1 only should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

IMPORTANT: If Item 2 or 3 is marked or Item 12 shows any injury, or other traumatic event, the medical examiner is informed of and given the opportunity to examine the patient.

-22494

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 8 9 3 0
REG. NO.

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Willard			2a. DATE OF DEATH MONTH DAY YEAR 10/25/86	2b. HOUR 1536 AM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 10 1919	6. AGE (IN YEARS LAST BIRTHDAY) 67	7a. UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Cecil Co	10. CITY OR TOWN OF DEATH Elkton
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital of Cecil County			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Millwright	12b. KIND OF BUSINESS OR INDUSTRY Wholesale Plumbing
13a. STATE Maryland			13b. COUNTY Cecil	13c. CITY OR TOWN Elkton
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 2200 Barksdale Rd. 21921	
14. FATHER'S NAME FIRST MIDDLE LAST Willard Philhower			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maggie E. Buckan	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. 215 16 6883	17. INFORMANT Pearl V. Philhower, 2200 Barksdale Rd.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebral hemorrhage</i>				
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Endstage Renal Failure</i>				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY STATE
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 10/24 19 86 , to 10/25 19 86 that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on 10/24 19 86 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did not view the body after death.				
22b. SIGNATURE <i>Andrew Nowakowski MD</i>	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 10/28/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANDREW NOWAKOWSKI MD	22e. ADDRESS 120 N. MAIN ST. B82 HHR, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 10/28/86	23c. NAME OF CEMETERY OR CREMATORIAL Gilpin Manor Memorial Pk. Elkton	23d. LOCATION CITY OR TOWN	23e. COUNTY STATE Cecil Md.
24. FUNERAL DIRECTOR NAME Hicks Home for Funerals	25a. DATE REC'D. BY REGISTRAR OCT 29 1986	25b. REGISTRAR'S SIGNATURE <i>Deeckie E. Hicks</i>		

00-33101

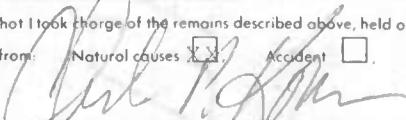
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1-4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PAGE 3. PAGE 4 SHOULD BE FORWARDED TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1-4 SHOULD BE KEPT ON FILE FOR 72 HOURS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 28431
1- STATE REGISTRAR			2a DATE KNOWN OF ESTI- DEATH MATED									2b. HOUR 0020 M
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			MONTH DAY YEAR
ARIETTA MURDOCK SMITH												10 14 1986
3 SEX	4. RACE	5 DATE OF BIRTH MONTH DAY YEAR	6 AGE (IN YEARS LAST BIRTHDAY) 79YRS. TR.	7 IF UNDER 1 YR. MONTHS	8 IF UNDER 24 HRS. DAYS	9 IF UNDER 24 HRS. HOURS	10 IF UNDER 24 HRS. MIN.	7c. DATE PRONOUNCED DEAD			MONTH DAY YEAR	2d HOUR 0020 M
F	WHITE	8 31 1907						10 14 1986				
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia			7b CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Cecil County			
10 CITY OR TOWN OF DEATH ELKTON, MD.			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH CITY, GIVE STREET ADDRESS) UNION HOSPITAL OF CEC. CO.			12a USUAL OCCUPATION (TYPE OF WORK) Housewife			12b. KIND OF BUSINESS OR INDUSTRY			
13a STATE Maryland			13b COUNTY Cecil			13c CITY OR TOWN Rising Sun			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e STREET ADDRESS 187 Sylmar Rd. 21911
14. FATHER'S NAME FIRST William MIDDLE Kegley LAST			15. MOTHER'S MAIDEN NAME FIRST Maggie MIDDLE Jane LAST Corvin									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 194-20-8127			17 INFORMANT Rising Sun, Md Frank Smith 187 Sylmar Rd. 21911						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) <i>Acute Myocardial Infarction</i>												
(c) <i>Atherosclerotic coronary vascular disease</i>												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1-a												
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY?						
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <i>Henry Farkas, MD</i>			TITLE (SPECIFY) <i>Assistant</i>			MEDICAL EXAMINER			DATE SIGNED <i>10/14/86</i>			
EXAMINER'S NAME (TYPE OR PRINT) <i>Henry Farkas, MD</i>			ADDRESS <i>Union Hosp. of Cecil County</i>									
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b DATE <i>10-18-1986</i>			23c NAME OF CEMETERY OR CREMATORIAL <i>Nottingham Bapt. Cem.</i>			23d LOCATION CITY OR TOWN <i>Nottingham</i> COUNTY <i>Chester</i> STATE <i>Penna.</i>			
24 FUNERAL DIRECTOR NAME <i>R.J. Farris</i>			ADDRESS <i>Rising Sun, Md 21911</i>			25a. DATE REC'D. BY REGISTRAR <i>OCT 20 1986</i>			25b. REGISTRAR'S SIGNATURE <i>R.J. Farris</i>			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PEN IN INQUIRIES. PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSPORT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201, PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

ITEMS, 18a, & 22a, G-621, by STATE OF MARYLAND FOR DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1- STATE MED. EX., 10/5/86 REGISTRAR Gbi										MEDICAL EXAMINER'S CERTIFICATE OF DEATH						REG. NO. 28732			
1. DECEASED NAME (TYPE OR PRINT)			MIDDLE			LAST			2a DATE KNOWN OF ESTI. DEATH MATED			MONTH DAY YEAR			2b. HOUR				
Steven L. Soots									<input checked="" type="checkbox"/>			10-19 1986							
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD			MONTH DAY YEAR			2d. HOUR	
Male		White		June 29 1985		1 yrs.		3 20				10-19 1986			11:21 a.m.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		9. NEVER MARRIED DIVORCED					9. BALTIMORE CITY OR COUNTY OF DEATH								
Maryland		U.S.A.		<input type="checkbox"/>		<input type="checkbox"/>		<input checked="" type="checkbox"/>			Cecil County,								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Elkton			Union Hospital of Cecil County						---										
13a. STATE Maryland			13b. COUNTY Cecil		13c. CITY OR TOWN Elkton			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 718 W. Pulaski Highway, 21921									
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST																
Ralph E. Loudermilk			Karen B.						B. Lewis										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 217 08 8490						17. INFORMANT Karen B. Soots, 718 W. Pulaski Highway, 21921										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART 1 DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
IMMEDIATE CAUSE (a) Acute & chronic tracheobronchitis associated with bronchopulmonary dysplasia.																			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?										
									YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion									
ACTUAL SIGNATURE 										TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER									
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS 111 Penn St., Balto., Md. 21201						DATE SIGNED 10-20-86										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial 10/22/86			23c. NAME OF CEMETERY OR CREMATORIAL Glipin Manor Mem. Park			23d. LOCATION CITY OR TOWN Elkton			COUNTY Cecil			STATE Md.				
24. FUNERAL DIRECTOR Hicks Home for Funerals			25a. DATE REC'D. BY REGISTRAR OCT 27 1986						25b. REGISTRAR'S SIGNATURE 										

6666-00

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, rehanded by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached (if used as the burial-travel permit). Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 28 shows any injury, or other traumatic death, the medical examiner will be summoned and one of the following will be done:

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH																		
8 6 2 8 9 3 3											REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
Benjamin			W.			Thompson						October 5, 1986					2:15AM _M	
3. SEX			4. RACE			5. DATE OF BIRTH			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male			Black			MONTH DAY YEAR			7 28 1918			68 YRS		MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			9 B. BALTIMORE CITY OR COUNTY OF DEATH			Perry Point Cecil MD.						
Pennsylvania			U.S.A.															
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
Perry Point			Perry Point Veteran Hospital						Truck Driver									
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			21921			
Maryland			Cecil			Elkton						112 Collins Avenue						
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST			
Charles						Thompson			Mary			Brown			Thompson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS									
YES			1942-1945			222 03 1288			VAMC, Perry Point, Maryland									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic lung cancer</u>																		
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metabolic disorder with hyperglycemia</u>																		
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>9-8-1986</u> to <u>10-5-1986</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>10-5-1986</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did <input checked="" type="checkbox"/> (not) <input type="checkbox"/> view the body after death.																		
22b. SIGNATURE <u>Michael Taylor, MD</u>			22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/>			MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input checked="" type="checkbox"/>		22d. DATE SIGNED 10-5-86					
22e. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL TAYLOR, M.D.			22f. ADDRESS VAMC, Perry Point, Maryland															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 10-11-86			23c. NAME OF CEMETERY OR CREMATORIAL St. John's Cemetery			23d. LOCATION CITY OR TOWN Newark			COUNTY		STATE Delaware				
24. FUNERAL DIRECTOR <u>Congo Funeral Home</u>			ADDRESS 201 N. Gray Ave., Wilm., DE						25a. DATE REC'D. BY REGISTRAR 10-08-1986			25b. REGISTRAR'S SIGNATURE <u>John L. Anderson</u>						

11005-00

7

Item #21d, G-621, 11/22/86 STATE OF MARYLAND
 FOR
 STATE M. Ex., / Gbj. DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 REGISTRAR MEDICAL EXAMINER'S CERTIFICATE OF DEATH

28934
 REG. NO.

00-22413
 TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1, AND 3 TO THE FUNERAL DIRECTOR, PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH	DAY	YEAR	2b. HOUR
DAVID H. WEIKERT, JR.						10-23-86	19			M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR
Male	White	Mar. 25, 1964	22 yrs.			10-23-86	19			7:10P
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Pennsylvania		U.S.A.					Cecil County			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Elkton		Union Hospital			Truck Driver					
13a. STATE Pennsylvania		13c. CITY OR TOWN York			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1720 Baron Drive, 17404			
14. FATHER'S NAME FIRST David		MIDDLE H.	LAST Weikert	15. MOTHER'S MAIDEN NAME FIRST Susan		16. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. 187-58-4185			17. INFORMANT Susan Pockalnik, Hanover, Pennsylvania		ADDRESS			
NO										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 8150 IMMEDIATE CAUSE (a) Head injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 3:50 P.M. 10-23-86			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) driver of an auto/fixed object/vehicle impact					
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) hwy.			21f. LOCATION STREET Md. Rt. 272, 2/10mi. S. of Wheatley Road CITY OR TOWN CITY OR TOWN COUNTY COUNTY STATE STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion					
ACTUAL SIGNATURE Margarita A. Korell, M.D.					TITLE (SPECIFY) Assistant M.D. MEDICAL EXAMINER					
EXAMINER'S NAME (TYPE OR PRINT)		Margarita A. Korell, M.D.			ADDRESS 111 Penn Street					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial		23c. NAME OF CEMETERY OR CREMATORIUM Greemount Cemetery		23d. LOCATION CITY OR TOWN York, Pennsylvania		23e. COUNTY Pennsylvania		23f. STATE
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc.		ADDRESS 1050 York Rd., Towson, Md.		25a. DATE REC'D. BY REGISTRAR OCT 29 1986		25b. REGISTRAR'S SIGNATURE John Ruck Towson				

11482-00

11482-00
NOTES



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove pages 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

80 28 435

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
A. VIRGINIA			Wilson	10	8	86	12:05 PM		
3. SEX	F	4. RACE	White	5. DATE OF BIRTH	MONTH	DAY	YEAR		
				Feb.	22	1908			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Canada	7b. CITIZEN OF WHAT COUNTRY?	U.S.A.	8	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH	Warwick	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	GRANAMS	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Secretary			12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE	Maryland	13b. COUNTY	Cecil	13c. CITY OR TOWN	Warwick	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS	MD.	
							Old Telegraph Road		
14. FATHER'S NAME	Frederick	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME	FIRST	MIDDLE	LAST		
				Hilma			Borstram		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	NO	16b. SOCIAL SECURITY NO.	186-54-3804	17. INFORMANT	ADDRESS			Elkton, Md.	
								Joan Colosimo 27 Norman Allen St.	
18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Alzheimer's Disease								3 years	
DUE TO, OR AS A CONSEQUENCE OF (b)									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE				
22a. I certify that (I) the deceased attended the deceased from <u>Sept</u> 19 85 to <u>Oct 8</u> 19 86, that (I) (we) lost saw the deceased alive on <u>8 Oct</u> 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE	DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED	
Wallace Obenshain, M.D.								9 Oct 86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS								
Wallace Obenshain	Cecilton, Maryland								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL	23d. LOCATION CITY OR TOWN	23e. COUNTY	STATE				
Burial	Oct. 10, 1986	CALVARY EPISCOPAL	St. John's	Chester	PA.				
24. FUNERAL DIRECTOR NAME	ADDRESS				25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE			
Edward McLean					Oct 14 1986	Julia Darden-Landress			
Free Funeral Home 259 E. Main St. Elkton									

30001-00



28453
REG. NO.

00-22141

THE JOURNAL OF CLIMATE

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR.
ITEM 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3 - RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL-CREMATION OR REMOVAL.

BP _____

DHMH-17
(VR A15 ME (5))
15M 2/80

1. DECEASED NAME (TYPE OR PRINT)				LAST				2a. DATE KNOWN OF ESTI- DEATH MATED				MONTH DAY YEAR				7b. HOUR							
Ida Christina Zahn								<input checked="" type="checkbox"/> 10/18 19 86				0004 M											
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) YRS.		7f. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN		7c. DATE PRONOUNCED DEAD		MONTH DAY YEAR				2d. HOUR					
Female		white		Feb. 13, 1908		78						10/18 19 86						0004 M					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		7c. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH																	
North Dakota		U.S.A.				Cecil County																	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY																	
Elkton		Union Hospital		Caretaker for Elderly																			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		MD													
Md.		Cecil		Elkton		YES <input checked="" type="checkbox"/>		108 St. Louis Drive		219021													
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST													
Samuel				Zahn		Mary Schmerice																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
No		216-07-1798		216-07-1798		Jo Ann Sonnick		108 St. Louis Dr.		Elkton, Md 21902													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>																							
Conditions, if any, which gave rise to immediate cause (a) stating the <u>under- lying cause last.</u>														DUE TO, OR AS A CONSEQUENCE OF									
{ (b) <u>Acute Myocardial Infarction</u>														DUE TO, OR AS A CONSEQUENCE OF				1.5 hours					
(c)																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?																			
				<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>																			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE		TITLE (SPECIFY)		M.D.		ASST. MEDICAL EXAMINER		DATE SIGNED		10/18/86													
EXAMINER'S NAME (TYPE OR PRINT)		Henry J. Farkas, M.D.																					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL CRATIN & FERRIS		23d. LOCATION CITY OR TOWN		23e. COUNTY		STATE													
Cremation		10/22/86		Cratin & Ferris		West Chester		Chester		Pa.													
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE																	
Joe Farkas		Funeral Home Elkton, Md.		OCT 24 1986																			

